Hiranandani
HOSPITAL
(A Fortis Network Hospital)

Hiranandani Fortis Hospital
Mini Seashore Road,
Sector 10 - A, Vashi,
Navi Mumbai - 400 703.
Tel. : +91-22-3919 9222
Fax : +91-22-3919 9220/21
Email : vashi@vashihospital.cor

BMI CHART

Date: 27 / 2 / 25

Name: Mr. Sachin Khairnar Age: 35 yrs Sex: M / F

BP: 120/80 mmHg Height (cms): 173 cm Weight(kgs): 74 kg BMI: _____

WEIGHT lbs	100	105	100	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195	200	205	210	215
kgs	45.5	47.7	50.50	52.3	54.5	56.8	59.1	61.4	63.6	65.9	68.2	70.5	72.7	75.0	77.3	79.5	81.8	84.1	86.4	88.6	90.9	93.2	95.5	97.7
HEIGHT in/cm	Underweight					Healthy					Overweight					Obese					Extremely Obese			
5'0" - 152.4	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42
5'1" - 154.9	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	36	37	38	39	40
5'2" - 157.4	18	19	20	21	22	22	23	24	25	26	27	28	29	30	31	32	33	33	34	35	36	37	38	39
5'3" - 160.0	17	18	19	20	21	22	23	24	24	25	26	27	28	29	30	31	32	32	33	34	35	36	37	38
5'4" - 162.5	17	18	18	19	20	21	22	23	24	24	25	26	27	28	29	30	31	31	32	33	34	35	36	37
5'5" - 165.1	16	17	18	19	20	20	21	22	23	24	25	25	26	27	28	29	30	30	31	32	33	34	35	35
5'6" - 167.6	16	17	17	18	19	20	21	21	22	23	24	25	25	26	27	28	29	29	30	31	32	33	34	34
5'7" - 170.1	15	16	17	18	18	19	20	21	22	22	23	24	25	25	26	27	28	29	29	30	31	32	33	33
5'8" - 172.7	15	16	16	17	18	19	19	20	21	22	22	23	24	25	25	26	27	28	28	29	30	31	32	32
5'9" - 176.2	14	15	16	17	17	18	19	20	20	21	22	22	23	24	25	25	26	27	28	28	29	30	31	31
5'10" - 177.8	14	15	15	16	17	18	18	19	20	20	21	22	23	23	24	25	25	26	27	28	28	29	30	30
5'11" - 180.3	14	14	15	16	16	17	18	18	19	20	21	21	22	23	23	24	25	25	26	27	28	28	29	30
6'0" - 182.8	13	14	14	15	16	17	17	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27	28	29
6'1" - 185.4	13	13	14	15	15	16	17	17	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27	28
6'2" - 187.9	12	13	14	14	15	16	16	17	18	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27
6'3" - 190.5	12	13	13	14	15	15	16	16	17	18	18	19	20	20	21	21	22	23	23	24	25	25	26	26
6'4" - 193.0	12	12	13	14	14	15	15	16	17	17	18	18	19	20	20	21	22	22	23	23	24	25	25	26

Doctors Notes:

Signature

Hiranandani Healthcare Pvt. Ltd.
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CIN : U85100MH2005PTC154823
GST IN: 27AABCH5894D1ZG | PAN NO: AABCH5894D

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UHID	12319236	Date	27/02/2023		
Name	Mr. Sachin Pundlik Kharatmal	Sex	Male	Age	35
OPD	Opthal 14				

Drug allergy: → Not Known
Sys illness: → No

C/o. No.

H/o. No. (Thyroid since 7-8 yrs).

Unaid V → Re 6/60, Le 6/60 [Blurr]

Refr → Re −4.75 / −1.00 X 20° 6/6.
Le −4.75 / −1.50 X 160° 6/6

NV → Re N6. Le N6

I.O.P → Re 15.0, Le 15.6

— Ⓡ WNL
— Ⓛ Dot on lens. opacity

— Kachi Candidate, CR 0.5, CR 0.4

MFR ⊕

[Consult for lasik]

Ⓕ WNL
Aggravate Surgery

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UHID	12319236	Date	27/02/2023		
Name	Mr. Sachin Pundlik Kharatmal	Sex	Male	Age	35
OPD	Dental 12				

Drug allergy:
Sys illness:

Supernumerary tooth = +8 (buccally erupted)

Caries +5/6

stains + calculus +

Treatment

Adv. extraction +8,1

Adv. filling +5/6

Adv oral prophylaxis

Dr Diksha Kaka

LABORATORY REPORT

MC-2275

PATIENT NAME : MR.SACHIN PUNDLIK KHARATMAL		**REF. DOCTOR :** SELF
CODE/NAME & ADDRESS : C000045507 - FORTIS FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : **0022WB005243** PATIENT ID : FH.12319236 CLIENT PATIENT ID: UID:12319236 ABHA NO :	AGE/SEX :35 Years Male DRAWN :27/02/2023 08:36:00 RECEIVED : 27/02/2023 08:36:35 REPORTED :27/02/2023 13:29:12

CLINICAL INFORMATION :

UID:12319236 REQNO-1377843
CORP-OPD
BILLNO-150123OPCR011749
BILLNO-150123OPCR011749

Test Report Status **Final**	Results	Biological Reference Interval	Units
HAEMATOLOGY - CBC			
CBC-5, EDTA WHOLE BLOOD			
BLOOD COUNTS, EDTA WHOLE BLOOD			
HEMOGLOBIN (HB) METHOD : SPECTROPHOTOMETRY	14.9	13.0 - 17.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : ELECTRICAL IMPEDANCE	5.10	4.5 - 5.5	mil/µL
WHITE BLOOD CELL (WBC) COUNT METHOD : DOUBLE HYDRODYNAMIC SEQUENTIAL SYSTEM(DHSS)CYTOMETRY	4.77	4.0 - 10.0	thou/µL
PLATELET COUNT METHOD : ELECTRICAL IMPEDANCE	305	150 - 410	thou/µL
RBC AND PLATELET INDICES			
HEMATOCRIT (PCV) METHOD : CALCULATED PARAMETER	44.8	40 - 50	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : CALCULATED PARAMETER	87.9	83 - 101	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED PARAMETER	29.3	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC) METHOD : CALCULATED PARAMETER	33.3	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : CALCULATED PARAMETER	**15.6 High**	11.6 - 14.0	%
MENTZER INDEX	17.2		
MEAN PLATELET VOLUME (MPV) METHOD : CALCULATED PARAMETER	10.1	6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT			
NEUTROPHILS METHOD : FLOWCYTOMETRY	53	40 - 80	%
LYMPHOCYTES METHOD : FLOWCYTOMETRY	37	20 - 40	%

Dr.Akta Dubey
Counsultant Pathologist

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Email : -

Patient Ref. No. 22000000831152

LABORATORY REPORT

MC-2275

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MONOCYTES METHOD : FLOWCYTOMETRY	07	2 - 10	%
EOSINOPHILS METHOD : FLOWCYTOMETRY	03	1 - 6	%
BASOPHILS METHOD : FLOWCYTOMETRY	00	0 - 2	%
ABSOLUTE NEUTROPHIL COUNT METHOD : CALCULATED PARAMETER	2.53	2.0 - 7.0	thou/µL
ABSOLUTE LYMPHOCYTE COUNT METHOD : CALCULATED PARAMETER	1.76	1.0 - 3.0	thou/µL
ABSOLUTE MONOCYTE COUNT METHOD : CALCULATED PARAMETER	0.33	0.2 - 1.0	thou/µL
ABSOLUTE EOSINOPHIL COUNT METHOD : CALCULATED PARAMETER	0.14	0.02 - 0.50	thou/µL
ABSOLUTE BASOPHIL COUNT METHOD : CALCULATED PARAMETER	**0 Low**	0.02 - 0.10	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR) METHOD : CALCULATED PARAMETER	1.4		
MORPHOLOGY			
RBC METHOD : MICROSCOPIC EXAMINATION	PREDOMINANTLY NORMOCYTIC NORMOCHROMIC		
WBC METHOD : MICROSCOPIC EXAMINATION	NORMAL MORPHOLOGY		
PLATELETS METHOD : MICROSCOPIC EXAMINATION	ADEQUATE		

Interpretation(s)
RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait
(<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.

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WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.
(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504
This ratio element is a calculated parameter and out of NABL scope.

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HAEMATOLOGY

ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD

E.S.R	05	0 - 14	mm at 1 hr

METHOD : WESTERGREN METHOD

Interpretation(s)
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD-**TEST DESCRIPTION** :-
Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition.CRP is superior to ESR because it is more sensitive and reflects a more rapid change.

TEST INTERPRETATION
Increase in: Infections, Vasculities, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.
Finding a very accelerated ESR**(>100 mm/hour)** in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).
In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.
Decreased in: Polycythermia vera, Sickle cell anemia

LIMITATIONS
False elevated ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia
False Decreased : Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)

REFERENCE :
1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition;2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin;3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis,10th edition.

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Fortis SRL Diagnostics

MC-2275

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IMMUNOHAEMATOLOGY

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP METHOD : TUBE AGGLUTINATION	TYPE A		
RH TYPE METHOD : TUBE AGGLUTINATION	POSITIVE		

Interpretation(s)
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-
Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

Disclaimer: "Please note, as the results of previous ABO and Rh group (Blood Group) for pregnant women are not available, please check with the patient records for availability of the same."

The test is performed by both forward as well as reverse grouping methods.

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BIOCHEMISTRY			
LIVER FUNCTION PROFILE, SERUM			
BILIRUBIN, TOTAL METHOD : JENDRASSIK AND GROFF	0.44	0.2 - 1.0	mg/dL
BILIRUBIN, DIRECT METHOD : JENDRASSIK AND GROFF	0.12	0.0 - 0.2	mg/dL
BILIRUBIN, INDIRECT METHOD : CALCULATED PARAMETER	0.32	0.1 - 1.0	mg/dL
TOTAL PROTEIN METHOD : BIURET	7.4	6.4 - 8.2	g/dL
ALBUMIN METHOD : BCP DYE BINDING	4.2	3.4 - 5.0	g/dL
GLOBULIN METHOD : CALCULATED PARAMETER	3.2	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO METHOD : CALCULATED PARAMETER	1.3	1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT) METHOD : UV WITH P5P	16	15 - 37	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT) METHOD : UV WITH P5P	30	< 45.0	U/L
ALKALINE PHOSPHATASE METHOD : PNPP-ANP	77	30 - 120	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT) METHOD : GAMMA GLUTAMYLCARBOXY 4NITROANILIDE	32	15 - 85	U/L
LACTATE DEHYDROGENASE METHOD : LACTATE -PYRUVATE	158	100 - 190	U/L
GLUCOSE FASTING,FLUORIDE PLASMA			
FBS (FASTING BLOOD SUGAR) METHOD : HEXOKINASE	**101 High**	74 - 99	mg/dL
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD			

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HBA1C	5.4	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%
METHOD : HB VARIANT (HPLC)			
ESTIMATED AVERAGE GLUCOSE(EAG)	108.3	< 116.0	mg/dL
METHOD : CALCULATED PARAMETER			
KIDNEY PANEL - 1			
BLOOD UREA NITROGEN (BUN), SERUM			
BLOOD UREA NITROGEN	15	6 - 20	mg/dL
METHOD : UREASE - UV			
CREATININE EGFR- EPI			
CREATININE	1.06	0.90 - 1.30	mg/dL
METHOD : ALKALINE PICRATE KINETIC JAFFES			
AGE	35		years
GLOMERULAR FILTRATION RATE (MALE)	93.86	Refer Interpretation Below	mL/min/1.73m2
METHOD : CALCULATED PARAMETER			
BUN/CREAT RATIO			
BUN/CREAT RATIO	14.15	5.00 - 15.00	
METHOD : CALCULATED PARAMETER			
URIC ACID, SERUM			
URIC ACID	5.6	3.5 - 7.2	mg/dL
METHOD : URICASE UV			
TOTAL PROTEIN, SERUM			
TOTAL PROTEIN	7.4	6.4 - 8.2	g/dL
METHOD : BIURET			
ALBUMIN, SERUM			
ALBUMIN	4.2	3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING			
GLOBULIN			

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GLOBULIN METHOD : CALCULATED PARAMETER	3.2	2.0 - 4.1	g/dL
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM, SERUM METHOD : ISE INDIRECT	139	136 - 145	mmol/L
POTASSIUM, SERUM METHOD : ISE INDIRECT	4.45	3.50 - 5.10	mmol/L
CHLORIDE, SERUM METHOD : ISE INDIRECT	105	98 - 107	mmol/L

Interpretation(s)

Interpretation(s)
LIVER FUNCTION PROFILE, SERUM-LIVER FUNCTION PROFILE
Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice.Elevated levels results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors &Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.
AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver,liver cancer,kidney failure,hemolytic anemia,pancreatitis,hemochromatosis. AST levels may also increase after a heart attack or strenuous activity.ALT test measures the amount of this enzyme in the blood.ALT is found mainly in the liver, but also in smaller amounts in the kidneys,heart,muscles, and pancreas.It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health.AST levels increase during acute hepatitis,sometimes due to a viral infection,ischemia to the liver,chronic hepatitis,obstruction of bile ducts,cirrhosis.
ALP is a protein found in almost all body tissues.Tissues with higher amounts of ALP include the liver,bile ducts and bone.Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Paget""s disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia,Malnutrition,Protein deficiency,Wilson""s disease.GGT is an enzyme found in cell membranes of many tissues mainly in the liver,kidney and pancreas.It is also found in other tissues including intestine,spleen,heart, brain and seminal vesicles.The highest concentration is in the kidney,but the liver is considered the source of normal enzyme activity.Serum GGT has been widely used as an index of liver dysfunction.Elevated serum GGT activity can be found in diseases of the liver,biliary system and pancreas.Conditions that increase serum GGT are obstructive liver disease,high alcohol consumption and use of enzyme-inducing drugs etc.Serum total protein,also known as total protein,is a biochemical test for measuring the total amount of protein in serum.Protein in the plasma is made up of albumin and globulin.Higher-than-normal levels may be due to:Chronic inflammation or infection,including HIV and hepatitis B or C,Multiple myeloma,Waldenstrom""s disease.Lower-than-normal levels may be due to: Agammaglobulinemia,Bleeding (hemorrhage),Burns,Glomerulonephritis,Liver disease, Malabsorption,Malnutrition,Nephrotic syndrome,Protein-losing enteropathy etc.Human serum albumin is the most abundant protein in human blood plasma.It is produced in the liver.Albumin constitutes about half of the blood serum protein.Low blood albumin levels (hypoalbuminemia) can be caused by:Liver disease like cirrhosis of the liver, nephrotic syndrome,protein-losing enteropathy,Burns,hemodilution,increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc
GLUCOSE FASTING,FLUORIDE PLASMA-**TEST DESCRIPTION**
Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and sothat no glucose is excreted in the

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Patient Ref. No. 22000000831152

PATIENT NAME : MR.SACHIN PUNDLIK KHARATMAL		**REF. DOCTOR :** SELF
CODE/NAME & ADDRESS : C000045507 - FORTIS FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : **0022WB005243** PATIENT ID : FH.12319236 CLIENT PATIENT ID: UID:12319236 ABHA NO :	AGE/SEX :35 Years Male DRAWN :27/02/2023 08:36:00 RECEIVED :27/02/2023 08:36:35 REPORTED :27/02/2023 13:29:12

CLINICAL INFORMATION :

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CORP-OPD
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Test Report Status **Final**	Results	Biological Reference Interval	Units

urine.
Increased in
Diabetes mellitus, Cushing' s syndrome (10 – 15%), chronic pancreatitis (30%). Drugs:corticosteroids,phenytoin, estrogen, thiazides.
Decreased in
Pancreatic islet cell disease with increased insulin,insulinoma,adrenocortical insufficiency, hypopituitarism,diffuse liver disease, malignancy (adrenocortical, stomach,fibrosarcoma), infant of a diabetic mother, enzyme deficiency diseases(e.g., galactosemia),Drugs- insulin, ethanol, propranolol; sulfonylureas,tolbutamide, and other oral hypoglycemic agents.
NOTE: While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values), there is wide fluctuation within individuals.Thus, glycosylated hemoglobin(HbA1c) levels are favored to monitor glycemic control.
High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-**Used For:**

1.Evaluating the long-term control of blood glucose concentrations in diabetic patients.
2.Diagnosing diabetes.
3.Identifying patients at increased risk for diabetes (prediabetes).
The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patients metabolic control has remained continuously within the target range.
1.eAG (Estimated average glucose) converts percentage HbA1c to md/dl, to compare blood glucose levels.
2. eAG gives an evaluation of blood glucose levels for the last couple of months.
3. eAG is calculated as eAG (mg/dl) = 28.7 * HbA1c - 46.7

HbA1c Estimation can get affected due to :
I.Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss,hemolytic anemia) will falsely lower HbA1c test results.Fructosamine is recommended in these patients which indicates diabetes control over 15 days.
II.Vitamin C & E are reported to falsely lower test results.(possibly by inhibiting glycation of hemoglobin.
III.Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia,uremia, hyperbilirubinemia, chronic alcoholism,chronic ingestion of salicylates & opiates addiction are reported to interfere with some assay methods,falsely increasing results.
IV.Interference of hemoglobinopathies in HbA1c estimation is seen in
a.Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
b.Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
c.HbF > 25% on alternate paltform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy
BLOOD UREA NITROGEN (BUN), SERUM-Causes of Increased levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)
Causes of decreased level include Liver disease, SIADH.
CREATININE EGFR- EPI-GFR— Glomerular filtration rate (GFR) is a measure of the function of the kidneys. The GFR is a calculation based on a serum creatinine test. Creatinine is a muscle waste product that is filtered from the blood by the kidneys and excreted into urine at a relatively steady rate. When kidney function decreases, less creatinine is excreted and concentrations increase in the blood. With the creatinine test, a reasonable estimate of the actual GFR can be determined.
A GFR of 60 or higher is in the normal range.
A GFR below 60 may mean kidney disease.
A GFR of 15 or lower may mean kidney failure.
Estimated GFR (eGFR) is the preferred method for identifying people with chronic kidney disease (CKD). In adults, eGFR calculated using the Modification of Diet in Renal Disease (MDRD) Study equation provides a more clinically useful measure of kidney function than serum creatinine alone.
The CKD-EPI creatinine equation is based on the same four variables as the MDRD Study equation, but uses a 2-slope spline to model the relationship between estimated GFR and serum creatinine, and a different relationship for age, sex and race. The equation was reported to perform better and with less bias than the MDRD Study equation, especially in patients with higher GFR. This results in reduced misclassification of CKD.
The CKD-EPI creatinine equation has not been validated in children & will only be reported for patients = 18 years of age. For pediatric and childrens, Schwartz Pediatric Bedside eGFR (2009) formulae is used. This revised "bedside" pediatric eGFR requires only serum creatinine and height.
URIC ACID, SERUM-**Causes of Increased levels:-**Dietary(High Protein Intake,Prolonged Fasting,Rapid weight loss),Gout,Lesch nyhan syndrome,Type 2 DM,Metabolic syndrome
Causes of decreased levels-Low Zinc intake,OCP,Multiple Sclerosis
TOTAL PROTEIN, SERUM-Serum total protein,also known as total protein, is a biochemical test for measuring the total amount of protein in serum..Protein in the plasma is made up of albumin and globulin

Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstrom''''''''''''''''''''s disease

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Patient Ref. No. 22000000831152

MC-2275

PATIENT NAME : MR.SACHIN PUNDLIK KHARATMAL **REF. DOCTOR :** SELF

CODE/NAME & ADDRESS : C000045507 - FORTIS FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : **0022WB005243** PATIENT ID : FH.12319236 CLIENT PATIENT ID: UID:12319236 ABHA NO :	AGE/SEX :35 Years Male DRAWN :27/02/2023 08:36:00 RECEIVED :27/02/2023 08:36:35 REPORTED :27/02/2023 13:29:12

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Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage),Burns,Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome,Protein-losing enteropathy etc.
ALBUMIN, SERUM-Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc.

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BIOCHEMISTRY - LIPID			
LIPID PROFILE, SERUM			
CHOLESTEROL, TOTAL	140	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC,CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE			
TRIGLYCERIDES	**237 High**	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY			
HDL CHOLESTEROL	**29 Low**	< 40 Low >/=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG			
LDL CHOLESTEROL, DIRECT	95	< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High	mg/dL
METHOD : DIRECT MEASURE WITHOUT SAMPLE PRETREATMENT			
NON HDL CHOLESTEROL	111	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
METHOD : CALCULATED PARAMETER			
VERY LOW DENSITY LIPOPROTEIN	**47.4 High**	</= 30.0	mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	**4.8 High**	3.3 - 4.4 Low Risk 4.5 - 7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk	
METHOD : CALCULATED PARAMETER			
LDL/HDL RATIO	**3.3 High**	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
METHOD : CALCULATED PARAMETER			

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MC-2275

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Interpretation(s)

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CLINICAL PATH - URINALYSIS

KIDNEY PANEL - 1

PHYSICAL EXAMINATION, URINE

COLOR	PALE YELLOW		
METHOD : PHYSICAL			
APPEARANCE	CLEAR		
METHOD : VISUAL			

CHEMICAL EXAMINATION, URINE

PH	6.0	4.7 - 7.5	
METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD			
SPECIFIC GRAVITY	1.025	1.003 - 1.035	
METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)			
PROTEIN	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE			
GLUCOSE	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD			
KETONES	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE			
BLOOD	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN			
BILIRUBIN	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT			
UROBILINOGEN	NORMAL	NORMAL	
METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRLICH REACTION)			
NITRITE	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE			
LEUKOCYTE ESTERASE	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY			

MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION			

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LABORATORY REPORT

MC-2275

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PUS CELL (WBC'S) METHOD : MICROSCOPIC EXAMINATION	2-3	0-5	/HPF
EPITHELIAL CELLS METHOD : MICROSCOPIC EXAMINATION	0-1	0-5	/HPF
CASTS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED		
CRYSTALS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED		
BACTERIA METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED	
YEAST METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED	
REMARKS	URINARY MICROSCOPIC EXAMINATION DONE ON URINARY CENTRIFUGED SEDIMENT		

Interpretation(s)

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Test Report Status **Final**	Results	Biological Reference Interval	Units
BIOCHEMISTRY			
GLUCOSE, POST-PRANDIAL, PLASMA			
PPBS(POST PRANDIAL BLOOD SUGAR) METHOD : HEXOKINASE	84	70 - 139	mg/dL

Comments

NOTE:- POST PRANDIAL PLASMA GLUCOSE VALUES. TO BE CORRELATE WITH CLINICAL, DIETETIC AND THERAPEUTIC HISTORY.

Interpretation(s)
GLUCOSE, POST-PRANDIAL, PLASMA-High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.Additional test HbA1c

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LABORATORY REPORT

MC-2984

PATIENT NAME : MR.SACHIN PUNDLIK KHARATMAL **REF. DOCTOR :** SELF

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Test Report Status **Final**	Results	Biological Reference Interval	Units
SPECIALISED CHEMISTRY - HORMONE			
THYROID PANEL, SERUM			
T3	100.40	80 - 200	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			
T4	8.14	5.1 - 14.1	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			
TSH (ULTRASENSITIVE)	**15.620 High**	0.270 - 4.200	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			

Comments

NOTE: PLEASE CORRELATE VALUES OF THYROID FUNCTION TEST WITH THE CLINICAL & TREATMENT HISTORY OF THE PATIENT.

Interpretation(s)

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SPECIALISED CHEMISTRY - TUMOR MARKER

PROSTATE SPECIFIC ANTIGEN, SERUM

PROSTATE SPECIFIC ANTIGEN	0.414	< 1.4	ng/mL

METHOD : ELECTROCHEMILUMINESCENCE,SANDWICH IMMUNOASSAY

Interpretation(s)
PROSTATE SPECIFIC ANTIGEN, SERUM-- PSA is detected in the male patients with normal, benign hyperplastic and malignant prostate tissue and in patients with prostatitis.
- PSA is not detected (or detected at very low levels) in the patients without prostate tissue (because of radical prostatectomy or cystoprostatectomy) and also in the female patient.
- It a suitable marker for monitoring of patients with Prostate Cancer and it is better to be used in conjunction with other diagnostic procedures.
- Serial PSA levels can help determine the success of prostatectomy and the need for further treatment, such as radiation, endocrine or chemotherapy and useful in detecting residual disease and early recurrence of tumor.
- Elevated levels of PSA can be also observed in the patients with non-malignant diseases like Prostatitis and Benign Prostatic Hyperplasia.
- Specimens for total PSA assay should be obtained before biopsy, prostatectomy or prostatic massage, since manipulation of the prostate gland may lead to elevated PSA (false positive) levels persisting up to 3 weeks.
- As per American urological guidelines, PSA screening is recommended for early detection of Prostate cancer above the age of 40 years. Following Age specific reference range can be used as a guide lines-

Age of male	Reference range (ng/ml)
40-49 years	0-2.5
50-59 years	0-3.5
60-69 years	0-4.5
70-79 years	0-6.5

(* conventional reference level (< 4 ng/ml) is already mentioned in report,which covers all agegroup with 95% prediction interval)

References- Teitz ,textbook of clinical chemiistry, 4th edition) 2.Wallach's Interpretation of Diagnostic Tests

****End Of Report****

Please visit www.srlworld.com for related Test Information for this accession

Dr. Swapnil Sirmukaddam
Consultant Pathologist

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PERFORMED AT :
SRL Ltd
BHOOMI TOWER, 1ST FLOOR, HALL NO.1, PLOT NO.28 SECTOR 4, KHARGHAR
NAVI MUMBAI, 410210
MAHARASHTRA, INDIA
Tel : 9111591115,
CIN - U74899PB1995PLC045956

Patient Ref. No. 22000000831152

sachin kharatmal 2/27/2023 11:38:12 AM
35 Years Male

HC

Rate 62 . Sinus rhythm.....normal P axis, V-rate 50- 99
. Nonspecific T abnormalities, lateral leads.....T <-0.10mV, I aVL V5 V6

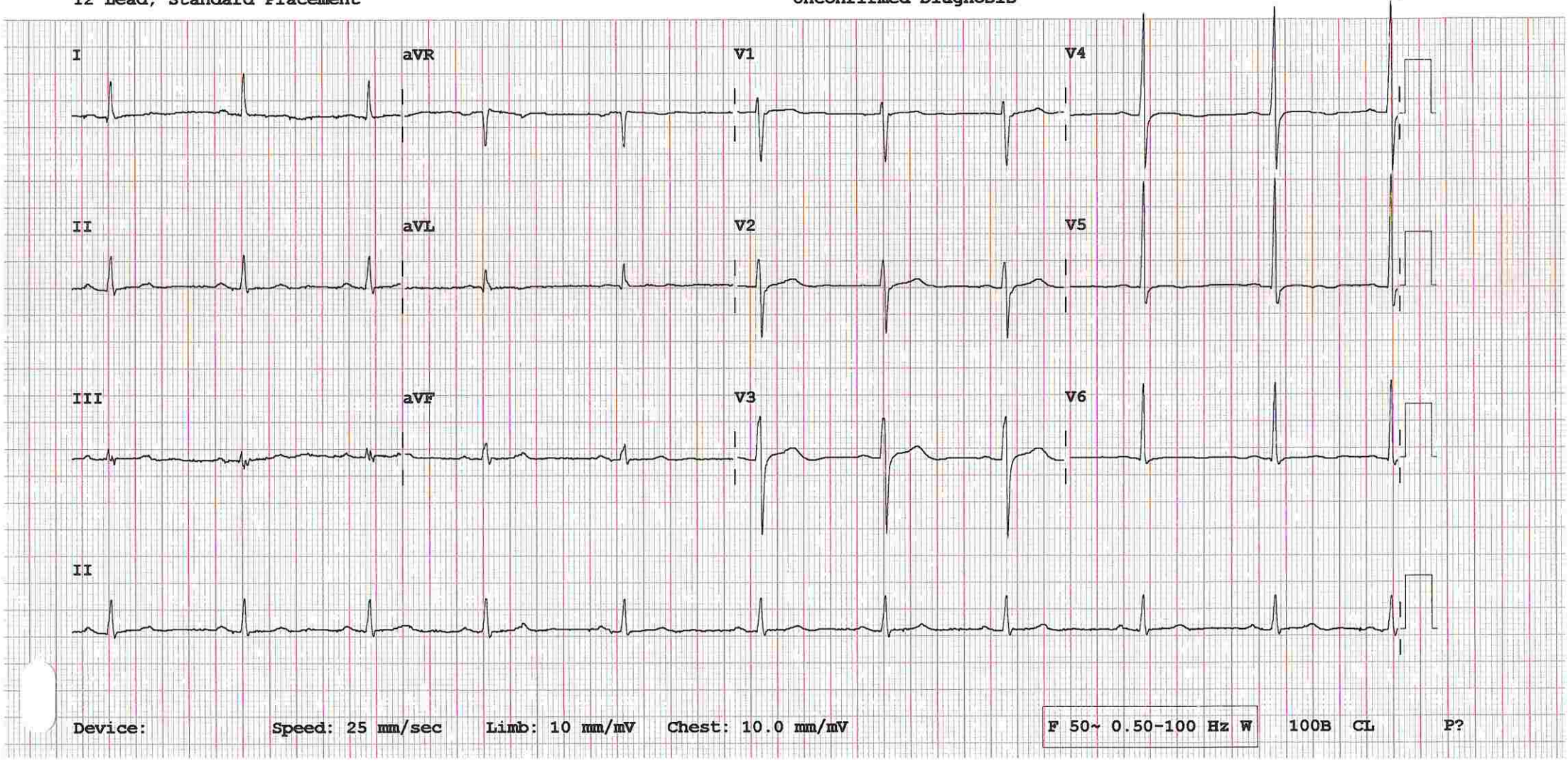
PR 173
QRSD 95
QT 392
QTc 398

--AXIS--
P 47
QRS 38
T 82

NSR
ST-T flattening in V4-V6

- ABNORMAL ECG -

12 Lead; Standard Placement Unconfirmed Diagnosis



Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV F 50~ 0.50-100 Hz W 100B CL P?

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GST IN : 27AABCH5894D1ZG
PAN NO : AABCH5894D

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Hiranandani HOSPITAL (A Fortis Network Hospital)

Date: 27/Feb/2023

DEPARTMENT OF NIC

Name: Mr. Sachin Pundlik Kharatmal
Age | Sex: 35 YEAR(S) | Male
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 12319236 | 11935/23/1501
Order No | Order Date: 1501/PN/OP/2302/24755 | 27-Feb-2023
Admitted On | Reporting Date : 27-Feb-2023 17:48:11
Order Doctor Name : Dr.SELF .

ECHOCARDIOGRAPHY TRANSTHORACIC

FINDINGS:

- No left ventricle regional wall motion abnormality at rest.
- Normal left ventricle systolic function. LVEF = 60%.
- No left ventricle diastolic dysfunction.
- No left ventricle Hypertrophy. No left ventricle dilatation.
- Structurally normal valves.
- No mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- No tricuspid regurgitation. No pulmonary hypertension.
- Intact IAS and IVS.
- No left ventricle clot/vegetation/pericardial effusion.
- Normal right atrium and right ventricle dimensions.
- Normal left atrium and left ventricle dimension.
- Normal right ventricle systolic function. No hepatic congestion.

M-MODE MEASUREMENTS:

LA	31	mm
AO Root	30	mm
AO CUSP SEP	21	mm
LVID (s)	26	mm
LVID (d)	41	mm
IVS (d)	09	mm
LVPW (d)	10	mm
RVID (d)	29	mm
RA	30	mm
LVEF	60	%

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DOPPLER STUDY:

E WAVE VELOCITY: 0.7 m/sec.
A WAVE VELOCITY:0.5 m/sec
E/A RATIO:1.6

	PEAK (mmHg)	MEAN (mmHg)	V max (m/sec)	GRADE OF REGURGITATION
MITRAL VALVE	N			Nil
AORTIC VALVE	05			Nil
TRICUSPID VALVE	N			Nil
PULMONARY VALVE	2.0			Nil

Final Impression :

Normal 2 Dimensional and colour doppler echocardiography study.

DR. PRASHANT PAWAR
DNB(MED), DNB (CARDIOLOGY)

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DEPARTMENT OF RADIOLOGY

Date: 27/Feb/2023

Name: Mr. Sachin Pundlik Kharatmal	**UHID | Episode No : 12319236 | 11935/23/1501**
Age | Sex: 35 YEAR(S) | Male	**Order No | Order Date: 1501/PN/OP/2302/24755 | 27-Feb-2023**
Order Station : FO-OPD	**Admitted On | Reporting Date : 27-Feb-2023 11:45:11**
Bed Name :	**Order Doctor Name : Dr.SELF .**

X-RAY-CHEST- PA

Findings:

Both lung fields are clear.

The cardiac shadow appears within normal limits.

Trachea and major bronchi appear normal.

Both costophrenic angles are well maintained.

Bony thorax appears unremarkable.

Aditya

DR. ADITYA NALAWADE
M.D. (Radiologist)

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E

DEPARTMENT OF RADIOLOGY

Date: 27/Feb/2023

Name: Mr. Sachin Pundlik Kharatmal	**UHID | Episode No : 12319236 | 11935/23/1501**
Age | Sex: 35 YEAR(S) | Male	**Order No | Order Date: 1501/PN/OP/2302/24755 | 27-Feb-2023**
Order Station : FO-OPD	**Admitted On | Reporting Date : 27-Feb-2023 10:13:13**
Bed Name :	**Order Doctor Name : Dr.SELF .**

US-WHOLE ABDOMEN

LIVER is normal in size and shows moderately raised echogenicity. No IHBR dilatation. No focal lesion is seen in liver. Portal vein appears normal in caliber.

GALL BLADDER is physiologically distended. Gall bladder reveals normal wall thickness. No evidence of calculi in gall bladder. No evidence of pericholecystic collection. **CBD** appears normal in caliber.

SPLEEN is normal in size and echogenicity.

BOTH KIDNEYS are normal in size and echogenicity. The central sinus complex is normal. No evidence of calculi/hydronephrosis.
Right kidney measures 8.8 x 4.3 cm.
Left kidney measures 11.0 x 5.0 cm.

PANCREAS is normal in size and morphology. No evidence of peripancreatic collection.

URINARY BLADDER is normal in capacity and contour. Bladder wall is normal in thickness. No evidence of intravesical calculi.

PROSTATE is normal in size & echogenicity. It measures ~ 12 cc in volume.

No evidence of ascites.

A 1.1 x 0.5 cm sized well defined smooth marginated oval shaped hyperechoic lesion is noted in subcutaneous plane in the left iliac region.

IMPRESSION:

- **Grade II fatty infiltration of liver.**
- **Well defined smooth marginated oval shaped hyperechoic lesion is noted in subcutaneous plane in the left iliac region – findings are s/o subcutaneous lipoma.**

DR. ADITYA NALAWADE
M.D. (Radiologist)